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PHILADELPHIA - The day after published reports detailed botched cancer treatments, U.S. Rep. John Adler was standing outside the Philadelphia Veterans Administration Medical Center calling for an investigation.

"I worry about what will happen next if we don't fully investigate the level of supervision at VA hospitals across the country," he said.

Adler, D-3rd of Cherry Hill, learned of the problems at the Woodland Avenue hospital through newspaper reports over the weekend, which said 92 of 116 devices implanted to treat prostate cancer administered the wrong doses of radiation.

The procedures took place over a six-year period. The errors represented 80 percent of the surgeries.

"Eight percent would be too high; 80 percent is unbelievable," Adler said. "The fact that they let it go on for about six years is outrageous."

Adler, a member of the House Veterans Affairs Committee, is calling for an investigation.

He sent a letter to Veterans Affairs Committee Chairman Bob Filner, D-51st of San Diego, requesting hearings.

"It is unacceptable that the brave men and women who so selflessly served their country have been faced with poor treatment and neglect by the hospital created to protect them," Adler said in the letter. "Today we are facing numerous federal agencies that have turned a blind eye toward the treatment of our American heroes. We must determine the responsible parties, hold them accountable, and fix our system to prevent this problem from happening in the future."

Adler is confident Filner would hold hearings.

"I'll be disappointed if a month from now we're not starting to have public hearings on this problem," he said. "It's frightening to me that this went on for six years."

The hospital serves more than eight counties in New Jersey and Pennsylvania, including military personnel from Burlington County.

The treatment problems stem from a procedure called brachytherapy, in which a device that emits radiation is implanted in the body. In this case, doctors were implanting large numbers of small "seeds" the size of rice kernels.

Of the problematic procedures, 57 patients did not receive enough radiation and 35 received too

much. In some cases, patients did not receive enough radiation to the prostate but received too much to other parts of the body.

The program was suspended last year and the federal Nuclear Regulatory Commission continues to investigate.

Dale Warman, a spokesman for the medical center, said the hospital would cooperate with the investigation.

"As we have done throughout this process, Philadelphia VA Medical Center staff are prepared to share whatever records and information are necessary to discover what happened, why it happened, and to take steps to prevent it from happening again," Warman told The Associated Press.

While one doctor, who no longer works at the hospitral, has been blamed for most of the errors, Adler said the mistakes passed several layers of oversight.

The hospital did not have a peer review system in which doctors examine one another's work, Adler said.

The Associated Press contributed to this story.